Bureau of Licensure and Certification

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	NVN285AGC	B. WING	10/02/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MAR-VO	N SENIOR CARE	300 LA RU RENO, NV			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments		Y 000		
	This Statement of Deficiencies was gen a result of an annual State Licensure su Complaint Investigation conducted in you on 10/2/08. This State Licensure survey conducted by the authority of NRS 449. Powers of the Health Division.	rvey and ur facility y was	;		
	The facility is licensed for 18 Residentia for Group beds for elderly and disabled and/or persons with mental illnesses, Caresidents. The census at the time of the was 15. Ten resident files were reviewed four employee files were reviewed. One discharged resident file was reviewed.	persons, ategory I survey ed and			
	Complaint #NV00018791 was unsubsta	ntiated.			
	The findings and conclusions of any invitive the Health Division shall not be consiprohibiting any criminal or civil investigations or other claims for relief that material available to any party under applicable fixtate, or local laws.	trued as tions, y be		DEC 1 5 2008 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	
Y 070 SS=F	449.196(1)(f) Qualifications of Caregive training	r-8 hours	Y 070	gallouis da la company de la c	
	NAC 449.196 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility.				
	This Regulation is not met as evidence Based on record review on 10/2/08, the failed to ensure 3 of 4 employees met the training requirements.	facility ne annual			

f deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencie

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

(X6) DATE

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If continuation sheet 1 of 9



10/02/2008

AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLII					

IDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

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B. WING_ STREET ADDRESS, CITY, STATE, ZIP CODE

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Y 070	Continued From page 1		Y 070	8 hours training for employees # 1,293 was	12/8/08
- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1-	Findings include:	al ad Alba		completed on 12/8/08, please see attachment A. The	e su
	Employees #1, #2 and #3 had all worke facility for more than 12 months. Employee and #3 had no evidence of at least eight annual training in their employee files. If #2 had evidence of only 3.5 hours of an training in the last 12 months. Severity: 2 Scope: 3	yees #1 t hours of Employee		cample employee checklis will be willized (attach- ment B) to ensure that employee records are up to date a complete to	1 85
Y 072 SS=F	449.196(3) Qualications of Caregiver-M re-training	ed	Y 072	be monitored by employee #4 every 3 menths.	
	NAC 449.196 3. If a caregiver assists a resident of a r facility in the administration of any medi including, without limitation, an over-the medication or dietary supplement, the comust: (a) Receive, in addition to the training repursuant to NRS 449.037, at least 3 hor training in the management of medicatic caregiver must receive the training at le 3 years and provide the residential facilisatisfactory evidence of the content of the and his attendance at the training; and (b) At least every 3 years, pass an example relating to the management of medicatic approved by the Bureau.	cation, -counter aregiver equired urs of on. The ast every ity with he training			
	This Regulation is not met as evidence Based on record review on 10/2/08, the failed to ensure 2 of 2 employees who previous medication training met the re	facility had			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 2 of 9

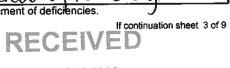


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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	NVN285AGC		B. WING	10/02/2008
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STATE, ZIP CODE	
MAR-VON SENIOR CARE		300 LA RUE RENO, NV		

MAR-VO	N SENIOR CARE	300 LA RUE AVE RENO, NV 89509		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMATION OF LSC ID	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 072	Continued From page 2 requirement. Findings include: Employees #1 and #2 completed initial medication training in 2005. Neither emphad evidence of at least three hours of medication re-training in the last three yes	ears.	The medication retraining course was completed by employee # 2 on 10/8/08- (attachment c), and employee #1 on 11/7/08 (attachment ment D). The sample employee checklist (attachment B) will be willized and will be monitored by	Lor
Y 175 SS=E	A49.209(4)(b) Health and Sanitation-Haze NAC 449.209 4. To the extent practicable, the premise facility must be kept free from: (b) Hazards, including obstacles that imprese movement of residents within and on the facility. This Regulation is not met as evidenced.	pes of the poede the putside	will be monitored by evnployee #4 every 3 months.	78/2
	Based on observation on 10/2/08, the administrator failed to ensure the facility of hazards. Findings include: 1. An upright vacuum cleaner and a fold wheelchair were stored in the exit corride to the back door of the facility. 2. A basement access panel made of ply was broken away from its frame. The paleaning against and into the ramp leadin the back door to the back yard. The uppedges and exposed screws on the pane hazard. 3. The facility dryer was located in the back the facility. The area behind and under the dryer had an accumulation of dryer less are cited, an approved plan of correction must be	was free Y 175 led or leading ywood anel was ig from per rough el were a asement erneath int.	we will make sure from now on that the hall-ways and access areas are free of clutters, obstacles and hazard. All equipments (cleaning, wheelchairs etc.) are kept in the basement storage area after even	Z ØD

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	NVN285AGC	B. WING	10/02/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MAR-VON SENIOR CARE

300 LA RUE AVE RENO, NV 89509

MAR-VON SENIOR CARE		RENO, NV	89509		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CO	(X5) MPLETE DATE
Y 175	Continued From page 3			employee #3	
	Severity: 2 Scope: 2 449.209(5) Health and Sanitation-Maint	ain Int/Ext	Y 178	The basement access parel 1 was replaced with a more	0/11/08
SS=C	NAC 449.209 5. The administrator of a residential factorist ensure that the premises are clean and interior, exterior and landscaping of the well maintained.	that the	-	the use of screws to secure it in place when raining or snowing. The area behind & under-1 neath the clothes dryer will be kept clean &	0/2/03
	This Regulation is not met as evidence Based on observation on 10/2/08, the failed to ensure the wall tiles in 1 of 1 st rooms were well maintained. Findings include:	acility		free of lint to be monitored by employee #3 daily at the end of the workday.	
	A main shower room was located in the across from bedroom #6. Along the bo of the shower, the grouting had eroded four of the base tiles and they were lear from the wall. The four wall tiles above tiles had also detached from the wall ar down behind the base tiles. There were areas of the tiled wall where there were the grouting around tiles. Severity: 1 Scope: 3	ttom edge around ning away the base ad had slid	¥148	the overall condition of the facility inside and basis and as needed.	11/08 OR 80
Y 876 SS=D	449.2742(4) NRS 449.037 NAC 449.2742		Y 876	Dusis and occurrent	
	4. Except as otherwise provided in this subsection, a caregiver shall assist in the subsection.	he			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Bureau of Licensure and C	ertification				FORM A	APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SU COMPLE	
	NVN285AGC		B. WING		10/02	2/2008
NAME OF PROVIDER OR SUPPLIE	2	STREET ADDR	ESS, CITY, STATE	ZIP CODE		
MAR-VON SENIOR CARE	I	300 LA RUE RENO, NV 8				
(X4) ID SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)

Y 876 Continued From page 4 administration of medication to a resideresident needs the caregiver's assistant caregiver may assist the ultimate user controlled substances or dangerous drift the conditions prescribed in subsection 449.037 are met. This Regulation is not met as evidence NRS 449.037 Adoption of standards, qualifications and other regulations. The Board shall adopt separate regarding the assistance which may be pursuant to NRS 453.375 and 454.213 ultimate user of controlled substances dangerous drugs by employees of resifacilities for groups. The regulations mat least the following conditions before assistance may be given: (d) The prescribed medication is not as by injection or intravenously. NRS 453.375 Authority to possess and administer controlled substances. A consultation and possessed and administer controlled substances. A consultation is persons: 6. An ultimate user or any person who	FULL (ATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
administration of medication to a resider resident needs the caregiver's assistar caregiver may assist the ultimate user controlled substances or dangerous drithe conditions prescribed in subsection 449.037 are met. This Regulation is not met as evidence NRS 449.037 Adoption of standards, qualifications and other regulations. 6. The Board shall adopt separate regulations are designed to NRS 453.375 and 454.213 ultimate user of controlled substances dangerous drugs by employees of resifacilities for groups. The regulations mat least the following conditions before assistance may be given: (d) The prescribed medication is not an aby injection or intravenously. NRS 453.375 Authority to possess and administer controlled substances. A consultation of the following persons: 6. An ultimate user or any person who		Y 876		
administration of medication to a resider resident needs the caregiver's assistar caregiver may assist the ultimate user controlled substances or dangerous drithe conditions prescribed in subsection 449.037 are met. This Regulation is not met as evidence NRS 449.037 Adoption of standards, qualifications and other regulations. 6. The Board shall adopt separate regarding the assistance which may be pursuant to NRS 453.375 and 454.213 ultimate user of controlled substances dangerous drugs by employees of resifacilities for groups. The regulations mat least the following conditions before assistance may be given: (d) The prescribed medication is not aby injection or intravenously. NRS 453.375 Authority to possess and administer controlled substances. A consubstance may be possessed and adriby the following persons: 6. An ultimate user or any person who				
NRS 449.037 Adoption of standards, qualifications and other regulations. 6. The Board shall adopt separate regulating the assistance which may be pursuant to NRS 453.375 and 454.213 ultimate user of controlled substances dangerous drugs by employees of resifacilities for groups. The regulations must least the following conditions before assistance may be given: (d) The prescribed medication is not an by injection or intravenously. NRS 453.375 Authority to possess and administer controlled substances. A consultation of the following persons: 6. An ultimate user or any person who	of ugs only if			
ultimate user designates pursuant to a agreement. Based on record review and interview the facility failed to ensure the files for residents contained an ultimate user a and that 1 of 10 residents did not required caregiver assistance with an injectable medication. Findings include: 1. The files for Residents #1, #6 and # contain a signed medication assistance agreement with the facility.	ulations e given to an or dential ust require such dministered introlled ninistered m the written on 10/2/08, 3 of 10 greement ire		insigned agreement for medication assistance for residents #1, #16 e #16 were in an iolstos (attachment E). Resident check list for will be utilized to make sure that the resident record is up to date & complete to be monitored by empleyed every 3 morths lattaching when the doctor prescribed the Forteo some subcu daily, it was also ordered that the nurse will give instruction to resident #9 on quing himself the injection. Resident #9 kept telling the nurse that he already it before when it was had it before when it was time to inject himself, he	10 a los

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Bureau o	of Licensure and Cer	tification					11/18/2008 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED
		NVN285AGC				10/02	2/2008
	ROVIDER OR SUPPLIER N SENIOR CARE		300 LA RI RENO, NV	JE AVE	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOOD CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
	micrograms (mcg) daily. The medicate an injection pen. Exassisted the resident prescribed dose. Severity: 2 Scope: 449.2742(5) OTC in Supplements NAC 449.2742 5. An over-the-cours supplement may be resident's physiciar administration of the writing or the facility.	prescribed Fotteo 7 per 3 milliliter (ml), 2 ion was administered mployee #2 reported nt by turning the pen 1 nedications & Dietar nter medication or a e given to a resident	d through d she to the dietary only if the plement in by	Y 876	would insist for ento turn the pen becauld not see ver the doctors office in was taken daily to doctors office for injection until the alth agency too the daily injection injection injection injection ment a.	ducte he word word word word word and word and word and and and and and and and and and an	550

This Regulation is not met as evidenced by: Based on record review and interview on 10/2/08, the facility failed to ensure over-the-counter (OTC) medications given to 2 of 10 residents were approved by their physician.

medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medication and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection

Findings include:

1 of NAC 449.2744.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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STATEMENT OF DEFICIENCIES
AND DUAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

X2) MULTIPLE CONSTRUCTION	
A BUILDING	

(X3) DATE SURVEY COMPLETED

NVN285AGC

B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

300 LA RUE AVE RENO, NV 89509

MAR-VON SENIOR CARE		RENO, NV 89509			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 885 SS=C	Continued From page 6 Resident #2: Physician's samples of I-O Multivitamins were in with the resident's medications. Employee #2 reported the resident's physician provided the sample resident. She stated the resident starte on 8/12/08 and was taking them through of the survey. There was no physician's for the vitamins in the resident's file and medication was not listed on the Septer October 2008 medication administration (MAR). Resident #10: Acidophillis chewable talevery even day, was listed on the resident every even day, was listed on the resident Employee #2 reported the resident's day brought the medication to the facility an instructed the caregivers to give the medication. Severity: 2 Scope: 1 449.2742(9) Medication / Destruction NAC 449.2742 9. If the medication of a resident is discontended from the facility does not claim physician and the expiration date of the medication of has passed, or a resident who has bee discharged from the facility does not claimedication, an employee of a residentis shall destroy the medication, by an accomethod of destruction, in the presence witness and note the destruction of the medication in the record maintained pure NAC 449.2744. Flushing contents of vibottles or other containers into a toilet is deemed to be an acceptable method of destruction of medication.	es for the d the pills in the day is approval if the imber or in records blets, one ent's MAR ughter d dication to continued, a resident in aim the all facility eptable of a resuant to ials, shall be		Resident tha: Prescription in for the 1-caps vitamins was received from the residents physician en 10/3/08 and is now supplied by the pharmacy and included in the Medication Administration Record provided by the pharmacy. Prescription for the Acidophilus was received on 10/2/08. Please see attachment I. Employee #2 will monitor that all medications (including over the counter medications) of every resident has a doctors order on file before it 16 given.	5000 10/2/08
l			I		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING
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(X3) DATE SURVEY COMPLETED

NVN285AGC

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MAR-VON SENIOR CARE		300 LA RU RENO, NV			
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Y 885	Continued From page 7		Y 885		
	This Regulation is not met as evidenced Based on observation and interview on the facility did not destroy 1 of 1 residen medications after they were discontinue expired.	10/2/08, t's			
	Resident #4 was prescribed Vesicare 10 milligrams (mg), one tablet daily, and it was not the September 2008 medication administration record (MAR) to be administration record (MAR) to be administration record on the multi-mount bubble packs that the Vesicare was discont 9/29/08. Employee #2 reported the rephysician instructed the facility to discort administration of the medication but the did not receive a written order. The employee stated she was destroying the Vesicare each night but had not documented the destruction.	mistered nistered nedication continued resident's ntinue the facility ployee tablets		Resident #4: Please see attachment J. for the doctors order to discortinue vesicare. All very order will be followed by employee #2 that we have the written order on file before discontinuing any	10/2/08 20/ 20/ 20/
	Resident #4 had two medication cards of Acetaminophen 500 mg tablets, prescrit one tablet every eight hours as needed. The medication was dispensed on 9/25 expired on 9/24/08. The 64 tablets of emedication had not been destroyed by the Severity: 1 Scope: 3	bed as for pain. /07 and xpired		medication of treatment Resident #4: The expired medication was destroy on 10/2/08. Attachment k was used to document the destruction and also	1 10 2108 pci
Y9999	Final Observations		Y9999	dates of as needed	
	NRS 449.095 Operator of residential fac groups: Posting of license and rates for A person who operates a residential fac s are cited, an approved plan of correction must be	services.		medications will be high lighted e will be moni by employee #2 every mor	1.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	NVN285AGC	B. WING	10/02/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

	A RUE AVE D, NV 89509 ID PROVIDER'S PLAN OF CORRECTION (X COMPRESS) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPRESS)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP
	TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
y9999 Continued From page 8 groups shall: 2. Post the rates for services provided by the residential facility for groups, in a conspicuou place in the residential facility for groups. Based on observation and interview on 10/2/the facility did not ensure its rates for rooms services were posted. Findings include: Rates for rooms and services were not postet the facility. The Administrator stated she had posted the rates. Severity: 1 Scope: 1	reses (please see 10/2 attachment L) was posted on 10/2/08 in plain view on the wall with all the licenses. Employee #4 will see to it that it's posted

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 9 of 9

